FINAL REPORT OF THE TASK FORCE TO DEVELOP PERFORMANCE QUALITY MEASURES FOR MANAGED BEHAVIORAL HEALTH CARE ORGANIZATIONS

EXECUTIVE SUMMARY

The Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations (the "Task Force") was created by the Maryland General Assembly in its 1999 legislative session with the passage of Senate Bill 585 (SB 585). This legislation designates the Executive Director of the Maryland Health Care Commission ("MHCC") as Chairman. The Task Force is charged with the development of measures of quality for the provision of *behavioral health care services* to members or enrollees of *managed behavioral health care organizations.* The Task Force was required to report its recommendations to the General Assembly by December 15, 1999.

By mid-November 1999, the Task Force realized that the absence of generally accepted measures of behavioral health quality coupled with the complexity of the arrangements between medical plans and managed behavioral health care organizations ("MBHOs") made the delivery of final recommendations by the statutory due date impossible. The Task Force, therefore, issued "The Interim Report of the Task Force to Develop Quality Measures for Managed Behavioral Health Care Organizations" (the "Interim Report.") One of the recommendations in the Interim Report was an extension of the due date for the final recommendations to December 15, 2000. The General Assembly concurred with delaying the final report.

After a three-month recess during the General Assembly's 2000 session, the Task Force began meeting regularly in mid-April 2000 and, by November, had developed its recommendations.

Recommendations

1. The unit of analysis for reporting behavioral health measures should be Health Maintenance Organizations ("HMOs") - not MBHOs.

2. Behavioral health reporting should be integrated into the MHCC's consumer reports for commercial HMOs; namely, *"Comparing the Quality of Maryland HMOs: A Guide for Consumers"* and *"Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland."*

3. A variety of descriptive indicators of behavioral health care should be publicly reported in the 2001 editions of the MHCC reports on HMOs. The indicators the Task Force recommends are:
   a. Enrollment in a managed behavioral health plan stated in member months by age and gender:
      i. Total enrollment;
      ii. Enrollment with a mental health benefit; and
      iii. Enrollment with a chemical dependency benefit.

b. Use of services including:
    i. Discharge rates and average inpatient length of stay for both mental health and chemical dependency; and
    ii. Utilization rates for both mental health and chemical dependency by age and gender.
c. Percentage of board certified physicians in behavioral health networks.
d. Number of practitioners by discipline (psychiatrists, psychologists, social workers, nurse psychotherapists, certified professional counselors, and licensed clinical alcohol and drug counselors).

The indicators specified in 3a. - 3c. should be publicly reported in the annual *"Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland."* The number of practitioners by discipline (3d.) should be publicly reported in the *"Comparing the Quality of Maryland HMOs: A Guide for Consumers."*

4. In addition, commercial HMOs should be required to submit the following for publication in the 2001 MHCC HMO reports:
    a. The two mental health related Health Plan Employer Data and Information Set ("HEDIS") measures reported by commercial HMOs:
        i. Antidepressant medication management; and
        ii. Use of appropriate follow-up after hospitalization for mental illness.
    b. The party responsible for behavioral health services: the HMO or an MBHO through a "carve-out" arrangement.
    c. The accreditation status of the MBHO under contract.
    d. A statement informing HMO members of their ability to obtain covered service outside the network of behavioral health providers and, if a member is able to obtain covered out-of-network diagnosis and treatment:
        i. The conditions that apply; and
        ii. The percentage of behavioral health patients who received some or all of their covered care out-of-network.

    The information specified in 4.a. - 4.d.i. should be reported in "*Comparing the Quality of Maryland HMOs: A Guide for Consumers."* The information in 4.d.ii. should be reported in *"Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland."*

5. Although the adoption of outcome measures as indicators of performance quality is not feasible at the current time, this option should be pursued in the future as more reliable and valid measures become available for assessing treatment of depression, childhood mental illness, chemical dependency, and other chronic mental illness.

6. Commercial HMOs should be required to survey patients' satisfaction in their behavioral health care setting using the Experience of Care and Health Outcomes ("ECHO") survey or a similar instrument that has been field-tested and validated. Because the collection and publishing of such data is costly, the Commission should support legislation to authorize the collection of behavioral health measures, including satisfaction.

7. The Task Force does not recommend the reporting of complaints by behavioral health providers or patients or the resolution of those complaints.

8. The Task Force, or a similarly constituted group, should be reconvened periodically to review the outcome of the ECHO survey field test and other measures of behavioral health quality as they become available. As with the current HMO reports, "Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland" and "Comparing the Quality of Maryland HMOs: A Guide for Consumers," and in accordance with Section 19-135(c) of the Health-General Article, the Commission shall have to approve all measures recommended for collection and HMOs shall have to receive advance notice of them.

I. Introduction

The Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations (the Task Force) was created by the Maryland General Assembly in its 1999 legislative session with the passage of Senate Bill 585 (attached as Appendix A). The Task Force was charged with the development of measures of quality for the provision of *behavioral health care services* to members or enrollees of *managed behavioral health care organizations (MBHOs). A managed behavioral health care organization* is defined as "a company, organization, or subsidiary that: contracts with a carrier to provide, undertake to arrange, or administer behavioral health care services to members; or otherwise makes behavioral health care services available to members through contracts with mental health care providers." *Behavioral health care services* are defined as "procedures or services rendered by a health care provider for the treatment of mental illness, emotional disorders, drug abuse, or alcohol abuse."

Task Force membership consists of the designees of the Secretary of the Department of Health and Mental Hygiene and the Maryland Insurance Commissioner, and the Executive Director of the Maryland Health Care Commission ("MHCC"), who is the Chairman. Other members were appointed by the MHCC based on nominations from professional associations or groups designated in the bill. Appendix B contains the names and affiliations of the Task Force members.

By statute, the Task Force must consider the following when developing the quality measures.

1. Discharge rates for members or enrollees who receive inpatient mental health and chemical dependency services.
2. The average length of stay for members or enrollees who receive inpatient mental health and chemical dependency services.
3. The percentage of enrollees receiving inpatient and outpatient services for mental health and chemical dependency.
4. Readmission rates of members and enrollees who receive inpatient mental health and chemical dependency treatment.
5. The level of patient satisfaction with the quality of managed behavioral health care services received.
6. Any other quality measures that the Task Force deems appropriate.

These provisions of law are actually part of the broader statute intended to focus on several aspects of the relationship between carriers (Health Maintenance Organizations ("HMOs") and insurers) and their providers of behavioral health care. The statute directs carriers, beginning October 2000, to annually file a mental health expense ratio with the Commissioner of the Maryland Insurance Administration ("MIA"). This requirement does not apply when risk for the cost of care is not assumed by the provider of behavioral health services (i.e., the carrier retains the responsibility for the cost of care, regardless of which entity issues payments for care). The portion of the law relating to development of quality measures is intended to complement the provisions relating to cost.

The Task Force's authority was effective October 1, 1999 with recommendations due by December 15, 1999. By December 1, 1999, the Task Force realized that its charge was extremely complex since instruments for assessing quality of behavioral care are still in development and the contractual relationships between MBHOs and carriers vary widely. Additional time to study the issues was necessary. On December 15, 1999, the Task Force issued "The Interim Report of the Task Force to Develop Quality Measures for Managed Behavioral Health Care Organizations" ("Interim Report"). This report, discussed in Chapter II, recommended an extension of the due date for the final recommendations to December 15, 2000. The report also made other recommendations of areas the Task Force would examine in future meetings. A complete listing of the interim recommendations is given in Appendix C.

II. Interim Report Overview

This chapter provides an overview and update of information presented as background in the Interim Report. A more comprehensive discussion of these issues can be found in the Interim Report.

A. Managed Behavioral Healthcare Organization Regulation

MBHOs are regulated in Maryland as "private review agents." This category of regulated entities includes any person, partnership or corporation performing medical and behavioral utilization review. If an MBHO enters into an agreement with an HMO to provide behavioral health services for a fixed fee, the terms of the agreement are subject to Maryland law governing "administrative service provider contracts." The MIA is responsible for assuring compliance with the law and regulations.

Private review agents, including MBHOs, must apply to the MIA and obtain a certificate of registration. This certificate is issued when applicants have met all the requirements set forth in both law and regulations. Specific requirements relate to treatment of alcoholism, drug abuse or mental illness meaning all private review agents, regardless of their lines of business, are subject to the same rules.

When an MBHO accepts payments from an HMO for providing behavioral health care services to HMO enrollees via contracts with providers, the MBHO is an "administrative service provider" ("ASP"). ASPs must submit a plan to the Insurance Commissioner designed to assure that they are able to reimburse the providers in their networks for patient care services. The HMO is ultimately liable for provider reimbursement.

Individual providers of behavioral mental health services are also regulated under Maryland's Health Occupations Article by specific professional licensing boards. Licensed and certified mental health and chemical dependency providers in Maryland are physicians, psychologists, social workers, nurse psychotherapists, and professional counselors.

B. Managed Behavioral Healthcare Organization Industry

During 1998, 72 percent or 162.2 million of the estimated 225 million Americans with health insurance were enrolled in some type of MBHO program. Approximately, 14.3 million additional Americans had behavioral health benefits provided through and managed internally by HMOs so that the total insured population with a managed behavioral health care component was 78 percent.[1] The estimated number of insured Americans in 1999 grew to 244 million (an 8.4 percent increase) and those enrolled in an MBHO grew to 176.8 million (a 9.0 percent increase). The proportion of insured Americans enrolled in an MBHO, therefore, remained at 72 percent. The number of Americans whose behavioral health benefits were both provided and managed by an HMO grew, however, to 18.8 million (a 31.5 percent increase). As result, the total insured population with a managed health care component increased to 80 percent.[2]

A few MBHOs continued to dominate the national market in 1999 with Magellan Behavioral Health and Value Options enrolling nearly half of the commercially insured population. The five largest MBHOs enroll nearly 70 percent of the commercially insured population.[3]

Open Minds, an industry research and consulting firm specializing in the behavioral and social services fields, evaluated five types of behavioral care programs in 1999:

- stand-alone behavioral health utilization review (UR) programs;
- stand-alone employee assistance programs ("EAPs");
- integrated EAP/managed behavioral health ("MBH") programs;
- non-risk based managed behavioral health network programs; and
- risk-based managed behavioral health network programs.

These programs may have a number of variations but the basic arrangements are as follows. In stand-alone UR programs, an MBHO's primary responsibility is arranging for and managing treatment of patients enrolled in a medical plan. The MBHO may pay claims but does not maintain a network of providers or assume risk.

In stand-alone EAPs, MBHOs agree to provide consultations to a business's employees and members of an employee's household (relation test does not apply) through a network of behavioral health providers. An EAP is an assessment and consultation service. Employees and household members are assessed or evaluated by a behavioral health provider who determines if behavioral health treatment is indicated. If it is, employees may then enter the behavioral health system for the treatments included in employers' benefit schedules. The number of assessments or evaluations to which employees and household members are entitled is established by agreement between employers and MBHOs. EAP services are offered to employers on a per member per month premium basis and providers are paid fee-for-service.

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1 *Managed Behavioral Health Market Share in the United States, 1998-1999*, pp 10-12. OPEN MINDS, Gettysburg, PA. 1999.

2 *The Yearbook of Managed Behavioral Health Market Share in the United States, 1999-2000*, p.6. OPEN MINDS, Gettysburg, PA. 2000.

3 *Ibid*, p. 12.

Integrated EAP/MBH programs combine the EAP function of assessment and evaluation with treatment under employers' behavioral health benefits.

An MBHO engaged in a non-risk-based program provides a panel of physicians, performs UR, and may pay claims but is not at risk for the cost of care. In addition to performing the duties of an MBHO engaged in a non-risk arrangement, a risk-based MBHO program assumes the risk for the cost of care. Table 1 provides 1999 MBHO enrollment and revenue per member per month by program. Nationally, the largest segment of the population receives behavioral health services through risk-based arrangements.

Table 1
MBHO Enrollment: 1999[4]

MBHO Program	Enrollment	Revenue PMPM
Utilization Review	33,500,000	$1.50
Stand Alone EAP	41,700,000	$0.95
Integrated EAP/MBH	14,200,000	$1.75
Non-Risk-Based	36,700,000	$1.71
Risk-Based	49,000,000	$3.87
Totals	176,800,000	

Comparable data for Maryland MBHOs are not available. A survey conducted by the MHCC staff in early 2000 focused on risk/non-risk arrangements and health plan types. The survey captured information for an estimated 80 percent of Marylanders having behavioral health coverage. Slightly more than 80 percent of the insured population is covered in a risk-based arrangement between their health plan and an MBHO with 53 percent of the insured population belonging to an HMO that has a risk-based arrangement.[5]

[4] *Industry Statistics,* p. 9. OPEN MINDS, Gettysburg, PA. July 1999.
[5] *Report on the MBHO Survey*, p. 1. Maryland Health Care Commission, Baltimore, MD May 2000.

Table 2 identifies the MBHO used by each of the fifteen commercial HMOs operating in Maryland whose 1998 premiums collected in Maryland exceeded $1,000,000.

Table 2
HMO-MBHO Affiliation
As of September 1, 2000

HMO	MBHO
Aetna U.S. Healthcare, Inc. - Maryland (AUSHC-MD)	Human Affairs International (HAI) - a Magellan Behavioral Health Company[1]
Aetna U.S. Healthcare, Inc. - Virginia (AUSHC-VA)	Human Affairs International (HAI) - a Magellan Behavioral Health Company[1]
CapitalCare HMO	Health Management Strategies
CIGNA HealthCare	CIGNA Behavioral Health[2]
FreeState Health Plans	Magellan Behavioral Health
Coventry Health Care	American Psych Systems
Delmarva Health Plan	Magellan Behavioral Health
Kaiser Permanente	Sheppard Pratt Health System
Optimum Choice	None[3]
Preferred Health Network	American Health Systems
Prudential HealthCare	PHC - Magellan
United HealthCare	United Behavioral Health[4]
George Washington University Health Plan	American Psych Systems

Notes
1. The AUSHC representative notes that some control is retained over the mental health/substance abuse ("MH/SA") benefit (e.g., the first level of patient/provider appeal takes place within AUSHC).
2. Both United HealthCare and United Behavioral Health are subsidiaries of the United Health Group.
3. Optimum Choice manages care in-house. The care is provided through a behavioral health care network called MAPSI.
4. The use of an MBHO is dictated by the insurance package purchased by an employer. Some packages do not carve-out the MH/SA benefit while others do.

C. Quality Assessment Measures

The classic formulation to quality assessment suggests the use of three categories: *structure*, *process,* and *outcomes.*[6] This formulation is still, virtually, universally accepted.

"Structure" addresses providers, both professional and institutional; how they are organized, staffed and located. Acceptable quality measures for professional providers include state licensure, board certification, and training. Similar measures for facilities include licensure, government program certification (e.g., Medicare), accreditation, and physical attributes.

[6] Donabedian, A. "Evaluating the Quality of Medical Care." Milbank Memorial Fund Quarterly 44:166-203, 1966.

"Process" addresses both personal and technical aspects of care and is often called "performance" in the jargon. The personal aspect includes patients' experiences with referral processes, appointment scheduling, provider punctuality, and provider-patient communication. The technical aspect includes diagnosis timeliness and therapeutic appropriateness, complication rates, and coordination across providers.

Outcomes of care may be assessed using clinical, functional and personal measures. Clinical outcome measures for mental health are related to symptoms, course of treatment, and remission or relapse. Functional outcome measures address patients' daily activities such as the nature of relationships and the ability to earn and/or maintain a living. Personal measures are less objective and include patients' assessments of both their care and current health status.

D. Accrediting Organizations

Two organizations dominate the accrediting of health care organizations and providers. Accreditation means that an organization or provider has met the quality and effectiveness standards of the accrediting body.

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that assesses and reports on the quality of managed care plans. The NCQA has been accrediting managed care organizations (MCOs) since 1991 and, more recently, managed behavioral health care organizations (MBHOs). Nationally, about half of all commercial HMOs, responsible for the health care of three-quarters of all HMO membership, are involved in the NCQA accreditation process.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an independent, not-for-profit health care standards-setting and accrediting body. The JCAHO accredits more than 18,000 health care organizations, including hospitals, health care networks, MCOs, and behavioral health care organizations.

E. Data Available

The Task Force's enabling legislation suggests the Task Force consider specific behavioral health-related statistics as well as patient satisfaction when developing performance quality measures - see Appendix A. Two of these statistics, discharge rates and average length of stay for both mental health and substance abuse (MH/SA), are currently reported by HMOs and publicly reported in the Commission's "*Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland*" (the "comprehensive report").[7] A third statistic, utilization rates for MH/SA, is reported by HMOs but is not publicly reported in the comprehensive report. Readmission rates are not reported nor publicly reported. Although enrollees' satisfaction with their HMOs is currently measured by the Consumer Assessment of

[7] Throughout its discussions, the Task Force used the term "substance abuse" to describe the health problems of alcoholism, drug addiction, etc. This term is also used in much of the behavioral health literature. NCQA and other organizations and authors use the term "chemical dependency" to characterize these same problems. The terms are synonymous in this report.

Health Plan Study (CAHPS), this survey does not address behavioral health exclusively. At the moment, there is no uniform, industry-wide method for measuring satisfaction with behavioral health care. A standard behavioral health satisfaction survey, the Experience of Care and Health Outcomes ("ECHO"), is under development and may become the industry standard by 2002. This survey is discussed in greater detail in Chapter III, Section D.

III. 2000 Performance Measures Issues

When the Task Force reconvened in April 2000, after a recess during the General Assembly session, the following issues were addressed:

A. The entity (HMO, MBHO) for which the measures should be reported
B. The media used to report measures (e.g., HMO reports, Web Site)
C. The desirability of reporting descriptive statistics
D. The desirability of reporting other HMO and MBHO information
E. The availability and credibility of outcome measures as quality measures
F. The availability and credibility of patient satisfaction surveys as quality measures
G. The availability and credibility of patient, family and provider complaints to state agencies, HMOs, and MBHOs as quality measures
H. Future activities

A. Reporting Unit

Although the enabling legislation suggests performance quality measures should be reported by MBHO, some members of the Task Force questioned the appropriateness of the MBHO as the unit for performance reporting. Concerns were raised about the varying contractual relationships between MBHOs and medical health plans, technical issues, and relevance of MBHO information to consumers.

MBHOs, as discussed in Chapter II.B., have several models for their contractual relationships with the medical plans with varying degrees of actual responsibility for the provision of care and record-keeping associated with it. Although MBHOs manage care through utilization and admissions review, they may not have responsibility for claims payment. In the majority of cases, some other entity, usually the MBHOs' clients (HMOs, PPOs, etc) process the claims. In these circumstances, MBHOs are dependent upon their clients for complete and accurate information. Second, many medical health plans provide a prescription drug benefit through their own or a separately contracted prescription drug plan, and MBHOs may not have a relationship with that prescription drug plan. Again, MBHOs are dependent on the prescription drug plan to record complete and accurate information and to report that information through the medical plan.

Other concerns relate to the ability to collect and analyze data. The MBHO industry has been undergoing a state of intense consolidation resulting in organizations without fully integrated information systems. Incompatible technology and incomparable information within an MBHO, therefore, may make obtaining comparable data for all of an MBHO's clients problematic. In addition, there are problems associated with reporting utilization of services. Payment data in a

fee-for-service environment are usually accurate for purposes of determining who got what and when. These data suffer from a time lag, however, in that providers may delay the submission of bills or the party responsible for paying claims may not do so in a timely fashion for any number of reasons. When a provider is capitated, there are no payments for individual services. In some capitated systems, there are "encounter" sheets, a document (perhaps a claim form) filed by providers that gives administrative and clinical information on patients diagnosed or treated. The use of encounter information is not universal and sometimes the data collected via this system are unreliable.

Another method of data collection, when authorization data are collected "up front" by MBHOs, avoids the lag problem associated with paid claims data. Authorization data may overstate actual usage, however, because they specify the amount and type of care to which patients are entitled and not the care patients receive. The authorization may provide for more treatments than are found necessary, patients may stop treatment in mid-course, or patients may not start treatments at all.

In a number of meetings, the Task Force returned to this issue of the appropriate "reporting unit:" MBHO, HMO, or both. The advantages and disadvantages of reporting by each entity were considered. The Task Force accepted the industry's assertion that some non-HMO plans are unable to specify the number of covered lives, relying instead on estimates. The Task Force concluded it did not want to rely on estimates in reporting data by MBHO. Second, the Task Force took into account the Commission's current reporting of statistical and quality measures for commercial HMOs. Throughout the discussions on reporting units, there was the expectation that eventually the reporting of quality measures for behavioral health would connect to or relate in some way to commercial HMO health reporting on the status of physical health.

Another issue raised was one of benefit design; that is, behavioral health benefits vary across medical plans and within medical plans because of administrative service only ("ASO") arrangements. Under self-insured ASO arrangements, employers may define unique benefit packages. Comparability within and across medical plans and consequently, MBHOs, exists only with respect to employers who are subject to the mandated benefit law or who voluntarily provide mandated benefits. The MBHO representatives on the Task Force felt strongly that benefit design could impact the assessment of quality and consumer satisfaction. Some members also noted that HMOs have a responsibility to their enrollees to assure that the care they receive through an MBHO is quality care. Finally, some members observed that HMO members have a tendency to believe that all the care that they receive is through the HMO. When arrangements between an HMO and an MBHO is such that patients are unaware they are receiving or will receive care through an MBHO, that is, the HMO-MBHO relationship is "transparent," information related to MBHOs is meaningless.

The Task Force did agree that information on MBHOs is helpful to providers when they are approached by MBHOs seeking to enroll them in their provider network. The Task Force also observed that equivalent benefits are likely to be managed differently across MBHOs and, to the extent these benefits could be identified, comparisons across MBHOs would be possible. The Task Force concluded that reporting for consumers should be by commercial HMO and that the

Commission's staff should continue to monitor internally the comparability of data reported by commercial HMOs served by the same MBHO to see if performance does vary by health plan.

The Task Force concluded that the HMO should be the entity for which behavioral health performance quality measures are reported.

B. Reporting Media

The Task Force considered the question of whether behavioral health measures should be reported separately or as part of the Commission's existing *"Comparing the Quality of Maryland HMOs: A Guide for Consumers"* (the "consumer report card"). It was decided that behavioral health measures should be integrated into the MHCC's consumer report card for commercial HMOs largely to consolidate consumer-useful information into one document. Task Force members also felt that including this information in a more general document would address consumer concerns about confidentiality when accessing information on behavioral health. Structural measures and some process measures can be reported in the initial report (2001 consumer report card for commercial HMOs). The patient satisfaction measures of behavioral health services should be phased-in for reporting after it has been determined that they are valid and reliable. Although the behavioral health performance indicators will be included in the general consumer report card, they will be presented in a separate section so that this information is easily retrievable. The same logic will be employed in the web-based design.

C. MBHO Statistics

The Task Force was required by the enabling legislation to consider four statistics in the development of quality measures: discharge rates; readmission rates; average length of stay; and percentage of enrollees receiving services. During its deliberations, the Commission's staff informed the Task Force that discharge rates and inpatient length of stay for both mental health and chemical dependency are *Health Plan Employer Data and Information Set* ("HEDIS") measures and are reported annually in the Commission's comprehensive report. The Task Force decided that this reporting should continue.

In addition, the percentage of enrollees receiving both mental health and chemical dependency treatment are HEDIS measures although they are not publicly reported by the Commission at this time. The Commission's staff supplied these rates for 1999 to the Task Force at the outset of its deliberations. The median percentages of enrollees in fifteen HMOs receiving any type of mental health or chemical dependency care were 3.9 percent and 0.2 percent, respectively. The Task Force favored reporting these utilization rates in the comprehensive report by age and sex.

Finally, the Task Force was informed that "readmission rate" is not a HEDIS measure and is not readily available. Readmission rates were HEDIS measures at one time but NCQA ceased collecting this statistic because NCQA's Committee on Performance Measurement ("CPM") believed it was not effective at discriminating between health plans. The CPM was also concerned over the inability to determine the clinical appropriateness of readmissions. Both HMOs and MBHOs ceased compiling this statistic after NCQA stopped requiring it. Moreover, the Task Force concluded that readmission rates are not good predictors of quality unless they

can be adjusted for case-mix and severity. Readmissions vary with the nature and the severity of the illness and the meaningful statistic would be the relationship of the expected readmission rate of the insured population to the actual readmission rate. A valid methodology to accomplish this comparison is not in place. Complicating this issue is the potential perverse incentive to avoid readmitting patients to enhance the "score" for this measure when readmission is clinically indicated. The Task Force concluded that this statistic should not be collected by the MHCC.

Some members of the Task Force were interested in turnover rates of behavioral health providers in plan networks. The reasons for turnover (e.g., dissatisfaction on part of network or physician) were seen as important adjuncts to this measure. Since the reasons cannot be determined, it was decided to exclude this measure from the performance reports.

D. HMO Reporting Requirements

The Task Force recommended that HMOs report the number of their members enrolled in a managed behavioral health plan. This statistic should be reported in terms of member months for: all members; those members having a mental health benefit; and those members having a substance abuse benefit. Further, these data should be categorized according to age and gender.[8] HMOs should also be required to report the percentage of board-certified physicians in their behavioral health networks as well as the number of practitioners by discipline. These statistics could be required for the 2001 commercial HMO consumer report card and comprehensive report.

Consumers will benefit if they are aware of the arrangements HMOs have for providing behavioral health care. As a result, the Task Force made the following recommendations with the intent of assisting consumers when they have the opportunity to select their HMO. These measures and information should be published in the 2001 MHCC commercial HMO reports:

- the two mental health-related HEDIS measures:
  - antidepressant medication management; and
  - use of appropriate follow-up after hospitalization for mental illness.
- the method by which behavioral health benefits are managed; that is, either directly or through a "carve-out" to a independent or subsidiary MBHO.
- the identity of the MBHO and its accreditation status with an accrediting body (e.g., JCAHO or NCQA).
- an indication of the ability of members to "opt-out" of the managed care network (i.e., obtain covered services outside the network of behavioral health providers), and the conditions that apply when a member obtains out-of-network diagnosis and treatment.

In addition, the MHCC should explore whether a reliable statistic is available to indicate, for both mental health and chemical dependency, the percentage of eligible members who were diagnosed or treated by an out-of-network provider.

[8] These data are currently HEDIS measures and are collected by the MHCC but not publicly reported.

E. Outcome Measures

The Task Force recognized early in the process that outcome measures are the most difficult to collect. While improved outcomes are clearly the benchmark for performance measurement, it is often difficult to appropriately adjust these measures for severity of mental illness. Moreover, the prevalence of mental illness may vary by covered population. Schizophrenia is diagnosed at a higher rate in the Medicaid population while depression is diagnosed at a higher rate in the commercially insured groups. The Task Force heard a presentation by Anthony Lehman, M.D. of the University of Maryland School of Medicine on these complexities.

On October 23, 2000, Task Force members attended a conference on outcome measures sponsored by the Maryland Psychological Association and the Center for Mental Health Services. The week after this conference, the Task Force met in regular session and Paul Berman, Ph.D., conference organizer, gave an overview of the proceedings. Dr. Berman informed the Task Force that one conclusion of the expert panel was that behavioral health measures should mirror what is reported in the "Getting Better/Living with Illness" section of the HMO consumer report card.[9] The best way to reach this goal is through the identification of treatment "best practices." The American Psychiatric Association is one group trying to develop "best practices" and reporting the results (outcomes) of such practices. In addition, while some members of the expert panel had reservations with certain aspects of the ECHO survey, Dr. Berman said those at the conference believe this survey is the best available for the commercial market.

The Task Force concluded that it is too early in the outcome measure development process to recommend the adoption of specific measures. As the process proceeds and measures are tested for their ability to gauge quality, the measures may be added to the set of HMO reporting requirements. In the meantime, the Task Force recommended collecting and reporting the antidepressant medication management and hospitalization follow-up HEDIS measures. Future outcome measures should cover assessing the effectiveness of treatment of depression, childhood mental illness/substance abuse, and other chronic mental illness.

F. Patient Satisfaction as a Quality Measure

The MHCC's HMO consumer report card contains the results of the Consumer Assessment of Health Plan Study ("CAHPS"). This survey asks HMO enrollees to rate their satisfaction with both overall and specific aspects of their relationships with their health plans. The CAHPS assesses satisfaction across all administrative and medical services provided by a health plan. Satisfaction with treatment of a specific disease or dysfunction is not reported at this time. This information would be both difficult and expensive to collect since it would involve oversampling to ensure that enough people with a particular problem were sampled so that the estimates are statistically significant.

With the advent of accreditation of MBHOs and an increasing emphasis on behavioral health care delivery and quality, a new consumer assessment tool aimed specifically at behavioral

[9] Measures in this report card section are related to diabetes care, cholesterol levels, post-heart attack treatment, blood pressure, and others.

health was developed through the cooperative efforts of the federal government and the private sector. Initially called the Consumer Assessment of Behavioral Health Services ("CAHBS"), the survey was renamed the Experience of Care and Health Outcomes ("ECHO"). The design of the ECHO survey drew on the experience of both the CAHPS and another behavioral health survey document, the Mental Health Statistics Improvement Program ("MHSIP"). The MHSIP is a "grass roots" consumer-oriented survey aimed at patients in public mental health systems and, as currently designed, is not appropriate for use in the private sector.

In April 2000, the MHCC staff was made aware of the pending field test of the ECHO survey by the Harvard Medical School. Susan Eisen, Ph.D. of the Harvard Medical School addressed the Task Force on this topic at its May 2000 meeting. Dr. Eisen provided an overview of health care satisfaction surveys, generally, and the ECHO survey, in particular. She also discussed the field test protocols, especially those that pertaining to confidentiality. Finally, she informed the Task Force that NCQA is considering requiring the use of the ECHO survey as a condition of accreditation.

In June 2000, a few MBHOs were invited to participate in the ECHO field testing. The MBHOs were asked to absorb the cost of drawing the enrollee samples and the MHCC agreed to fund the cost of survey administration. Harvard Medical School agreed to pay the cost of data analysis. One MBHO agreed to participate.

The participating MBHO has drawn the necessary sample and survey administration will begin in January 2001. Harvard anticipates receiving the data for analysis by the middle of spring 2001 with results reported to the MHCC by late spring. The MHCC will receive data aggregated from test sites around the country and regionally since the purpose of the survey is the assessment of the ECHO instrument as a measurement tool and not an assessment of the participating MBHO.

The Task Force concluded that satisfaction measures are worthwhile indicators of the performance of health care organizations. They recommended that enrollee satisfaction using the ECHO survey should be reported in the 2002 consumer report card if the ECHO survey is found reliable and valid after field testing by Harvard Medical School. The ECHO survey was selected in part for its comprehensiveness and also for it ease of administration since it can be added to the CAHPS survey already required.

The administration, verification, and reporting of results of a consumer satisfaction survey would be an expensive undertaking, with costs to both HMOs and the MHCC. Although the Commission currently has broad authority in this area, the fiscal implications of data collection of this magnitude merit legislative review. The Commission should, therefore, support legislation to authorize the collection of behavioral health measures, including satisfaction.

G. Enrollee, Patient and Provider Complaints

The Task Force discussed the usefulness of reporting internal and external complaints in its Interim Report. This examination actually began prior to the publication of the Interim Report with a presentation by a representative of the MIA's Appeals and Grievance Unit. That unit is responsible for adjudicating complaints involving medical necessity only. The Life and Health

Complaint Unit within the MIA is responsible for investigating complaints that do not relate to either medical necessity or quality of care. Complaints involving quality of care are the responsibility of the Office of Health Care Quality ("OHCQ") within the Department of Health and Mental Hygiene.

This issue was so important to the Task Force that, after the recess, an entire meeting was devoted to it. Presentations were made by representatives of two MBHOs, the MIA, OHCQ, and the Health Education and Advocacy Unit of the Office of Attorney General.

The Task Force learned from the MBHOs that patient satisfaction is a prime concern and that procedures are in place to receive, categorize, resolve, and report patient and provider complaints. Although MBHOs are trying to satisfy both patients and providers, the Task Force observed that the procedures and definitions used are not uniform, making comparable reporting impossible at the current time. One MBHO addressed this problem by submitting three suggestions to the Task Force for its consideration. If the Task Force is going to require MBHOs or other forms of managed care organizations to report internal complaint data, the Task Force must complete the following: establish standardized procedures, a common terminology, and consistent definitions for complaints; encourage consistency in internal review, investigations, and resolution processes across MCOs; and create a sensible interface between legislative requirements and benchmarks established by national accreditation standards.

The MIA acts as the collection and distribution point for patient and provider complaints. Complaints involving quality of care are referred to the OHCQ, which investigates complaints over care rendered by both institutional and professional providers. Evaluations of inpatient institutional complaints are made using JCAHO standards. Outpatient institutional complaints are the responsibility of the Maryland Mental Hygiene Administration. Although the OHCQ's jurisdiction is very diverse - ranging from patient care to environmental and administrative concerns – it has not received many behavioral health-related complaints. In a recent six-month period, less than ten complaints involving mental health services that were rendered to HMO members were received.

At its October meeting, the Task Force considered various options: (1) report complaints relating to behavioral health in the HMO consumer report card; (2) link the MHCC's website to the MIA's website where complaint data are available and publicize their availability in the hard copy of the HMO consumer report card; (3) indicate in the HMO consumer report card whether an MBHO has a process in place to handle complaints; (4) publish compliance with NCQA accreditation standards for complaints in the HMO consumer report card; or (5) develop a system for collecting and categorizing complaints about behavioral health services by MBHO. Other options were to combine these alternatives or disregard complaints as a performance measure.

The Task Force decided that a variety of factors, including the small number of complaints lodged annually with government agencies, inconsistency in ease of reporting and categorizing complaints, and variation in the seriousness of complaints, weigh against the adoption of a recommendation to use complaints as a performance quality measure at this time.

H. Future Activities

A number of unresolved issues remain as the Task Force approaches the December 2000 deadline for its final report. For example, the Task Force has recommended the adoption of the ECHO survey based on the assumption that this survey will become the counterpart to the CAHPS survey; that is, the ECHO survey can be efficiently undertaken without an undue financial burden on the industry and the results are widely acknowledged as accurate. If these assumptions are not confirmed by the field test, this recommendation will need to be revisited. Similarly, outcome measures are evolving and the Task Force believes that better descriptors of performance are on the horizon.

As a result of the advances being made in the behavioral health field, the members of the Task Force believe they, or a similarly constituted group, should be reconvened periodically to review current reporting requirements. The Task Force would decide what reportable measures should be added, replaced, or deleted. As with the current HMO reports, *"Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland"* and *"Comparing the Quality of Maryland HMOs: A Guide for Consumers,"* all measures recommended for collection will need to be approved by the Commission and notice will need to be given to the industry as statutorily required in Section 19-134(c) of the Health-General Article.

IV. Recommendations

A. Reporting Unit

The unit of analysis for reporting behavioral health measures should be HMOs, not MBHOs.

Discussion –

The Task Force believes that information on behavioral health should be directed to consumers and that the best way to accomplish this is by associating performance measures with HMOs rather than MBHOs. The Task Force also believes that, although MBHOs may be contractually responsible for providing care, HMOs have a responsibility to assure the quality of care given to their enrollees.

B. Reporting Media

Behavioral health reporting should be integrated into the MHCC's consumer reports for commercial HMOs; namely, "Comparing the Quality of Maryland HMOs: A Guide for Consumers" and "Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland."

Discussion –

Certain performance and descriptive measures should be publicly reported in the next edition of the consumer report card and comprehensive report; that is, the reports that will be available in September 2001.

C. MBHO Statistics

A variety of descriptive indicators of behavioral health care should be publicly reported in the 2001 editions of the MHCC reports on HMOs. The indicators the Task Force recommends are:

- *a. Enrollment in a managed behavioral health plan stated in member months by age and gender:*
  - *i. Total enrollment;*
  - *ii. Enrollment with a mental health benefit; and*
  - *iii. Enrollment with a chemical dependency benefit.*
- *b. Use of services including:*
  - *i. Discharge rates and average inpatient length of stay for both mental health and chemical dependency; and*
  - *ii. Utilization rates for both mental health and chemical dependency by age and gender.*
- *c. Percentage of board certified physicians in behavioral health networks.*
  - *iv. Number of practitioners by discipline (psychiatrists, psychologists, social workers, nurse psychotherapists, certified professional counselors, and licensed clinical alcohol and drug counselors).*

The indicators specified in a. -c. should be publicly reported in the annual "Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland." The number of practitioners (d.) should be publicly reported in "Comparing the Quality of Maryland HMOs: A Guide for Consumers."

Discussion –

Of the four statistics the Task Force was instructed by the enabling legislation to consider, two - discharge rates and average inpatient length of stay - are currently publicly reported in the comprehensive report. The Task Force recommends the reporting of the HEDIS statistics of mental health and chemical dependency utilization categorized by age and gender. The fourth statistic, readmission rates, was rejected by the Task Force on the grounds of relevance.

The Task Force's recommendation that would require the reporting of the percentage of board-certified physicians in behavioral health networks is consistent with reporting currently in place in the HMO comprehensive report for primary care physicians and certain specialists. As behavioral health networks, unlike medical/surgical networks, have only psychiatrists eligible for board-certification, the Task Force believes that the composition of the network is valuable to consumers. An MBHO's accreditation status may be the most important and concrete item of information for most consumers.

D. HMO Reporting Requirements

Commercial HMOs should be required to submit the following for publication in the 2001 MHCC HMO reports:

- *a. The two mental health related Health Plan Employer Data and Information Set ("HEDIS") measures reported by commercial HMOs:*
  - *i. Antidepressant medication management; and*
  - *ii. Use of appropriate follow-up after hospitalization for mental illness.*
- *c. The party responsible for behavioral health services: the HMO or an MBHO through a "carve-out" arrangement.*
- *d. The accreditation status of the MBHO under contract.*
- *d. A statement informing HMO members of their ability to obtain covered service outside the network of behavioral health providers and, if a member is able to obtain covered out-of-network diagnosis and treatment:*
  - *i. The conditions that apply; and*
  - *ii. The percentage of behavioral health patients who received some or all of their covered care out-of-network.*

The information specified in a. - d.i. should be reported in "Comparing the Quality of Maryland HMOs: A Guide for Consumers." The information in d.ii. should be reported in "Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland."

Discussion –

The Task Force affirmed the value of the continued reporting of the two HEDIS measures. Because the recommendation to designate HMOs as the reporting unit was based in part on some consumers' ignorance of the existence and purpose of MBHOs, the Task Force believes consumers will be more informed when they select an HMO if they are made aware of each HMO's arrangements for managing behavioral health and the alternatives for obtaining care.

E. Outcome Measures

Although the adoption of outcome measures as indicators of performance quality is at the current time, this option should be pursued in the future as more reliable and valid measures become available for assessing treatment of depression, childhood mental illness, chemical dependency, and other chronic mental illness.

Discussion –

The Task Force concluded that it is too early in the outcome measure development process to recommend the adoption of specific measures. As the development of measures proceeds and measures are tested for their ability to gauge quality, the measures may be added to the HMO reporting requirements. In the meantime, the Task Force recommended collecting and reporting the antidepressant medication management and hospitalization follow-up HEDIS measures. Future outcome measures to be developed should cover assessing the effectiveness of treatment of depression, childhood mental illness/substance abuse, and other chronic mental illness.

F. Patient Satisfaction Measures

1. *Commercial HMOs should be required to survey patients' satisfaction with their behavioral health care using the Experience of Care and Outcomes (ECHO) survey if and when this survey is judged to be valid in the field test being administered by Harvard Medical School.*
2. *The Commission should support legislation to authorize the collection of behavioral health measures including satisfaction.*

Discussion –

Commercial HMO enrollees and patients are surveyed annually using the Consumer Assessment of Health Plan Study (CAHPS) and the results are publicly reported in the MHCC's consumer report card. The CAHPS addresses satisfaction with administrative polices and is not specific with respect to behavioral health care. As required by its enabling legislation, the Task Force considered patient satisfaction with behavioral health and concluded that, although behavioral health is a small segment of total health care, it is a critically important segment, and recommends the measurement of patient satisfaction in the future.

Although the Commission currently has broad authority to collect information from HMOs, the fiscal implications of data collection of the magnitude of the ECHO survey merit legislative authorization.

G. Enrollee, Patient and Provider Complaints

The Task Force does not recommend the reporting of complaints by behavioral health providers or patients or the resolution of those complaints.

Discussion –

The Task Force studied this issue in great depth and concluded that a variety of factors, including the small number of complaints lodged annually with government agencies, inconsistency in ease of reporting and categorizing complaints, and variation in the seriousness of complaints weigh against the adoption of a recommendation to use complaints as a performance quality measure at this time.

H. Future Activities

The Task Force, or a similarly constituted group, should be reconvened periodically to review the outcome of the ECHO survey field test and other measures of behavioral health quality as they become available. As with the current HMO reports, "Comprehensive Performance Report: Commercial Health Maintenance Organizations in Maryland" and "Comparing the Quality of Maryland HMOs: A Guide for Consumers," and in accordance with Section 19-135(c) of the Health-General Article, the Commission shall have to approve all measures recommended for collection and HMOs shall have to receive advance notice of them.

Discussion –

The body of knowledge of behavioral health quality is increasing and adjusting to new therapies, drugs, and treatments. A set of measures adopted today may become outmoded or surpassed over time. The reporting requirements should be reviewed periodically - at least annually - to assure they reflect the current state of the art in performance measurement.

APPENDIX A

Enabling Legislation

Senate Bill 585 (1999)

SECTION 3. AND BE IT FURTHER ENACTED, That:

(a) There is a Task Force to Develop Performance Quality Measures for Managed Behavioral Health Care Organizations.

(b) The Task Force shall consist of the following 10 members:

(1) The Secretary of the Department of Health and Mental Hygiene, or the Secretary's designee;
(2) The Executive Director of the Health Care Access and Cost Commission [Maryland Health Care Commission];
(3) The Maryland Insurance Commissioner;
(4) One representative of the managed behavioral care organization industry, appointed by the Health Care Access and Cost Commission [Maryland Health Care Commission];
(5) Two representatives of carriers that use the services of a managed behavioral care organization, appointed by the Health Care Access and Cost Commission [Maryland Health Care Commission];
(6) One psychologist, appointed by the Maryland Psychological Association;
(7) One nurse psychotherapist, appointed by the Psychiatric Advanced Practice Nurses of Maryland;
(8) One psychiatrist, appointed by the Maryland Psychiatric Society; and
(9) One social worker, appointed by the Maryland Society for Clinical Social Work.

(c) The Executive Director of the Health Care Access and Cost Commission [Maryland Health Care Commission] shall serve as the Chairman of the Task Force.

(d) The Task Force shall develop measures of quality for the provision of behavioral health care services to members or enrollees of managed behavioral health care organizations.

(e) In developing the measures of quality, the Task Force shall consider:

(1) Discharge rates for members or enrollees who receive in-patient mental health and substance abuse services;
(2) The average length of stay for members or enrollees who receive in-patient mental health and substance abuse services;
(3) The percentage of enrollees receiving in-patient and out-patient services for mental health and substance abuse;
(4) Readmission rates of members and enrollees who receive in-patient mental health and substance abuse treatment;
(5) The level of patient satisfaction with the quality of managed behavioral health care services received; and
(6) Any other quality measures that the Task Force deems appropriate.

(f) The Task Force shall report its findings to the Senate Finance Committee and the House Economic Matters Committee by December 15, 1999.

Appendix B

Task Force Membership

TASK FORCE MEMBERS

Member and Employer	Representing
John Colmers, Chairman Maryland Health Care Commission	Maryland Health Care Commission
Paul C. Berman, Ph.D. Independent Practitioner	Maryland Psychological Association
Harry A. Brandt, M.D. Department of Psychiatry St. Joseph Medical Center	Maryland Psychiatric Society
Faith M. Couvillon, MS, LPC Magellan Behavioral Health	Managed behavioral care industry
Jim Gach, LCSW-C The Counseling Center	Maryland Society for Clinical Social Work
Brian M. Hepburn, M.D. Maryland Mental Health Administration	Secretary, Department of Health and Mental Hygiene
Kathleen Loughran Maryland Insurance Administration	Maryland Insurance Administration
David Nace, M.D. United Behavioral Health	Insurance Carrier
Peggy Soderstrom, Ph.D. JHU School of Nursing	Psychiatric Advanced Practice Nurses of Maryland

Appendix C

Interim Report Recommendations

Interim Report Recommendations

1. Request permission to delay final recommendations until December 15, 2000. Submit an interim report to the Maryland General Assembly on December 15, 1999.

2. Take a three-pronged approach to quality performance reporting:

    a. Identify in the interim report what is currently available and could be included in the HMO performance report in 2001;
    b. Decide in the final report what types of measures would be desirable and are feasible to develop; and
    c. Identify those indicators that would be desirable to develop, but are not currently feasible to report due to data collection, measurement issues, or cost.

3. Indicate the following in the 2001 MHCC HMO report card:

    a. HMOs that have behavioral managed health services in-house versus those who carve out these services;
    b. Mental health related HEDIS measures reported by commercial HMOs; and
    c. Accreditation status for carve-outs.

4. By 2001, attempt to combine and report HEDIS HMO mental health measures by MBHOs.

5. For the final report, the Task Force should:

    a. Explore how to expand quality measures beyond HMOs to fully insured plans;
    b. Determine usefulness and feasibility of collecting outcome measures;
    c. Determine the usefulness and feasibility of collecting information on patient satisfaction; and
    d. Determine the usefulness of reporting internal and external complaints. Internal complaints could be recorded and categorized by MBHOs; external complaints could be obtained from the MIA through Appeals and Grievance Process or the Department of Health and Mental Hygiene.

APPENDIX D

Minutes of the Task Force Meetings

(Available upon request)